In The Name Of God

1 **DEFINITIONS** — The terms dysphagia, odynophagia, and globus sensation are defined as follows:

- Dysphagia is a subjective sensation of difficulty or abnormality of swallowing.

Odyno phagia

Pain in swallowing+

- Globus sensation is a functional esophageal disorder characterized by a sensation of a lump, tightness or retained food bolus in the pharyngeal or cervical area

ACUTE DYSPHAGIA — The acute onset of inability to swallow solids and/or liquids including secretions suggests impaction of a foreign body in the esophagus

Food impaction is the most common cause for acute onset of dysphagia in adults

Clinical presentation — Patients usually develop symptoms after ingesting meat (most commonly beef, chicken, and turkey), which completely obstructs the esophageal lumen,

Management — The food bolus can be removed during upper endoscopy using grasping devices either en bloc or piecemeal, depending upon the consistency of the bolus

or it can be

gently pushed into the stomach using an endoscope

EVALUATION OF NONACUTE DYSPHAGIA

Distinguishing oropharyngeal from esophageal dysphagia

- **dysphagia** — The first step in evaluating patients with nonacute dysphagia is to determine if the symptoms are due to oropharyngeal or esophageal dysphagia based on the patient's answers

Oropharyngeal dysphagia – Oropharyngeal or transfer dysphagia is characterized by these features:

- Patients have difficulty initiating a swallow.
- Patients may point toward

" the cervical region as the site of their symptoms.

- Swallowing may be accompanied by

١٢ nasopharyngeal regurgitation, aspiration, and a sensation of residual food remaining in the pharynx.

- Oral dysfunction can lead to drooling, food spillage, sialorrhea, piecemeal swallows

dysarthria.

- Pharyngeal dysfunction can lead to coughing or choking during food

Esophageal dysphagia – Patients with esophageal dysphagia commonly report the following:

- Difficulty swallowing several seconds after initiating a swallow

- A sensation that foods and/or liquids are being obstructed in their passage from the upper esophagus to **cardia**

17 Patients may point to the suprasternal notch or to an area behind the sternum as the site of obstruction.

retrosternal dysphagia usually corresponds with the location of the lesion,

19 suprasternal dysphagia is commonly referred from below

20. **Solid, liquid, or both?**—A critical component of the medical history is determining the types of food that produce symptoms

21 Dysphagia to solids only is usually present when the esophageal lumen is narrowed to 13 mm or less by a stricture.

- **Progressive or intermittent?**—It is important to ask if the symptoms are intermittent or are gradually progressive.

Progressive Dysphagia

- 1.Slowly Progressive
- Peptic Stricture due to:
- GERD Or Radiation
- 2.Rapidly Progressive
- Less Than 6 mo
- CA Of Esophagus

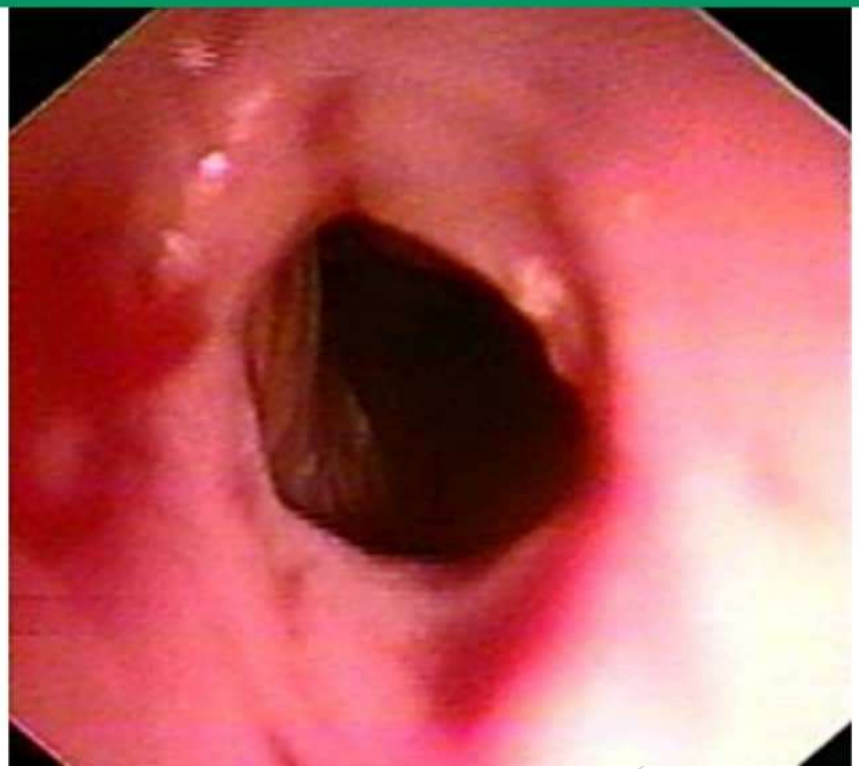
23 **Peptic stricture** — Peptic stricture is a complication of gastroesophageal reflux disease (GERD) and results from the healing process of erosive esophagitis.

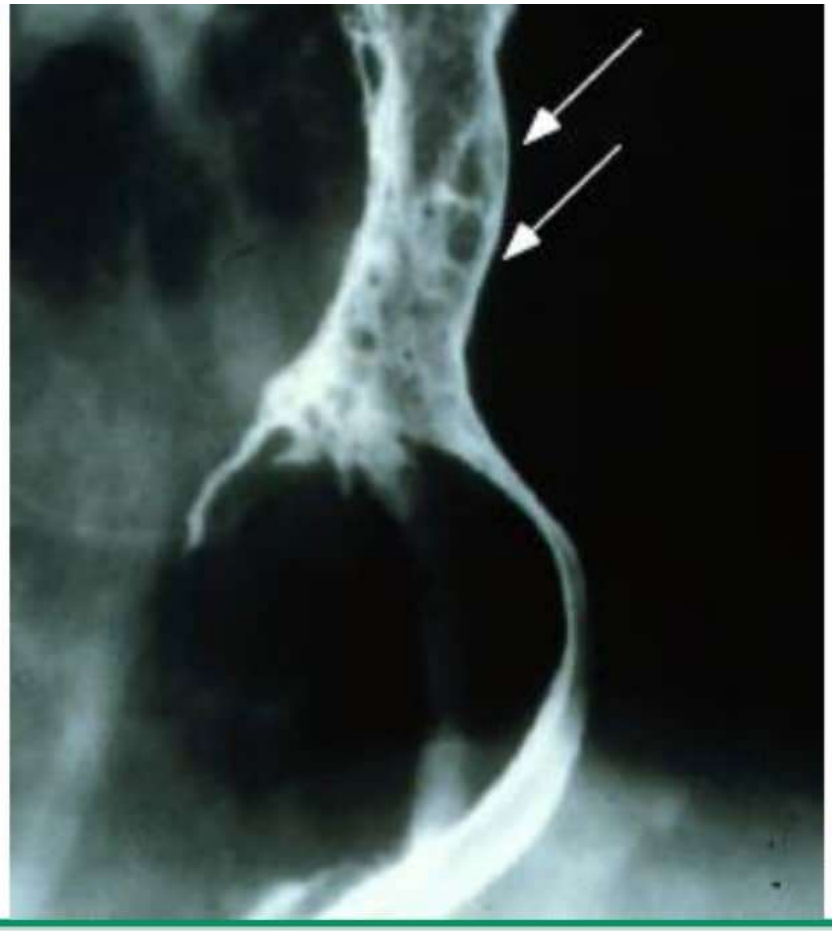
Dysphagia in GERD

- 1.PEPTIC STRICTURE
- Adeno carcinoma of esophagus
- Both seen in prolonged GERD

stricture

Peptic esophageal stricture





Esophagram demonstrates 6 cm long distal esophageal

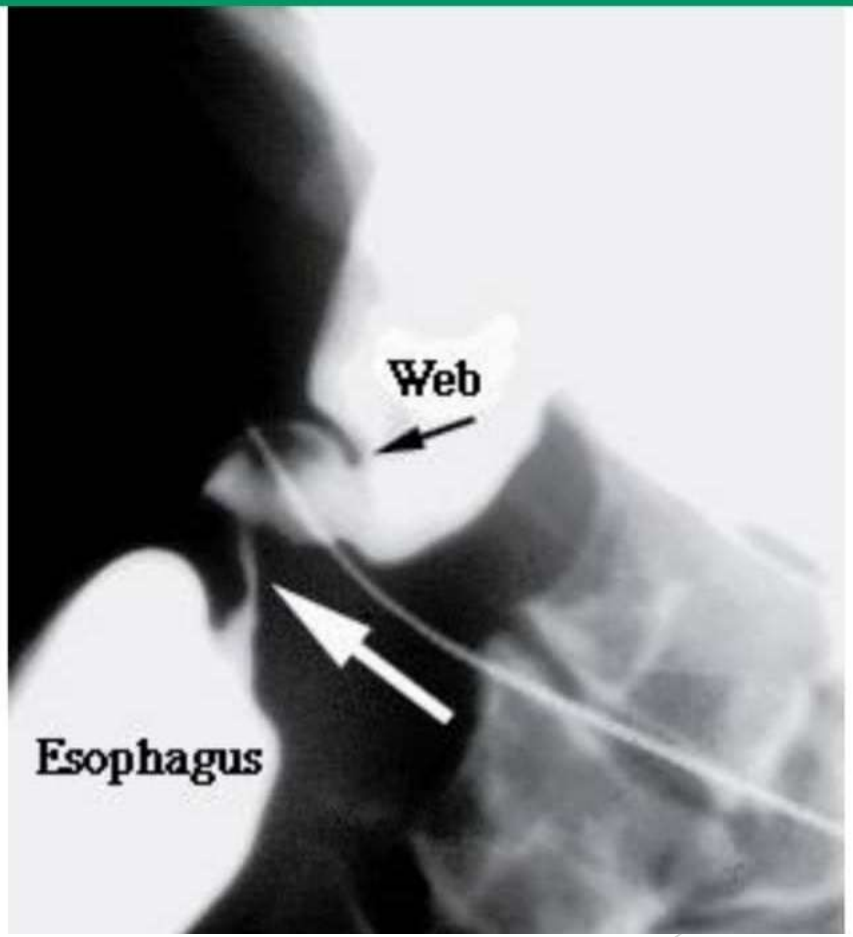
Carcinoma — Cancer of the esophagus or gastric cardia is associated with rapidly progressive dysphagia, initially for solids and later for liquids. In addition, patients may have chest pain, odynophagia, anemia, anorexia

Alarm Signs in Dysphagia

.Anemia
.Wt loss 5% in 6 to 12 mo
.G.I.B
.Vomiting
.Older Than 60 year
.Anorexia
Odynophagia.
Chest pain
Rapid progressive

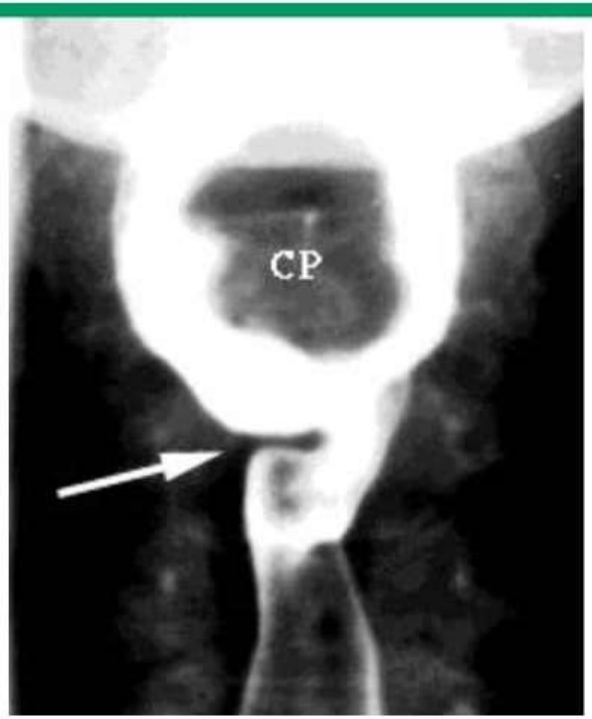
Solids only with intermittent symptoms — Dysphagia to solid foods only that is intermittent in nature may be caused by eosinophilic esophagitis, esophageal ring or web, or a vascular anomaly.

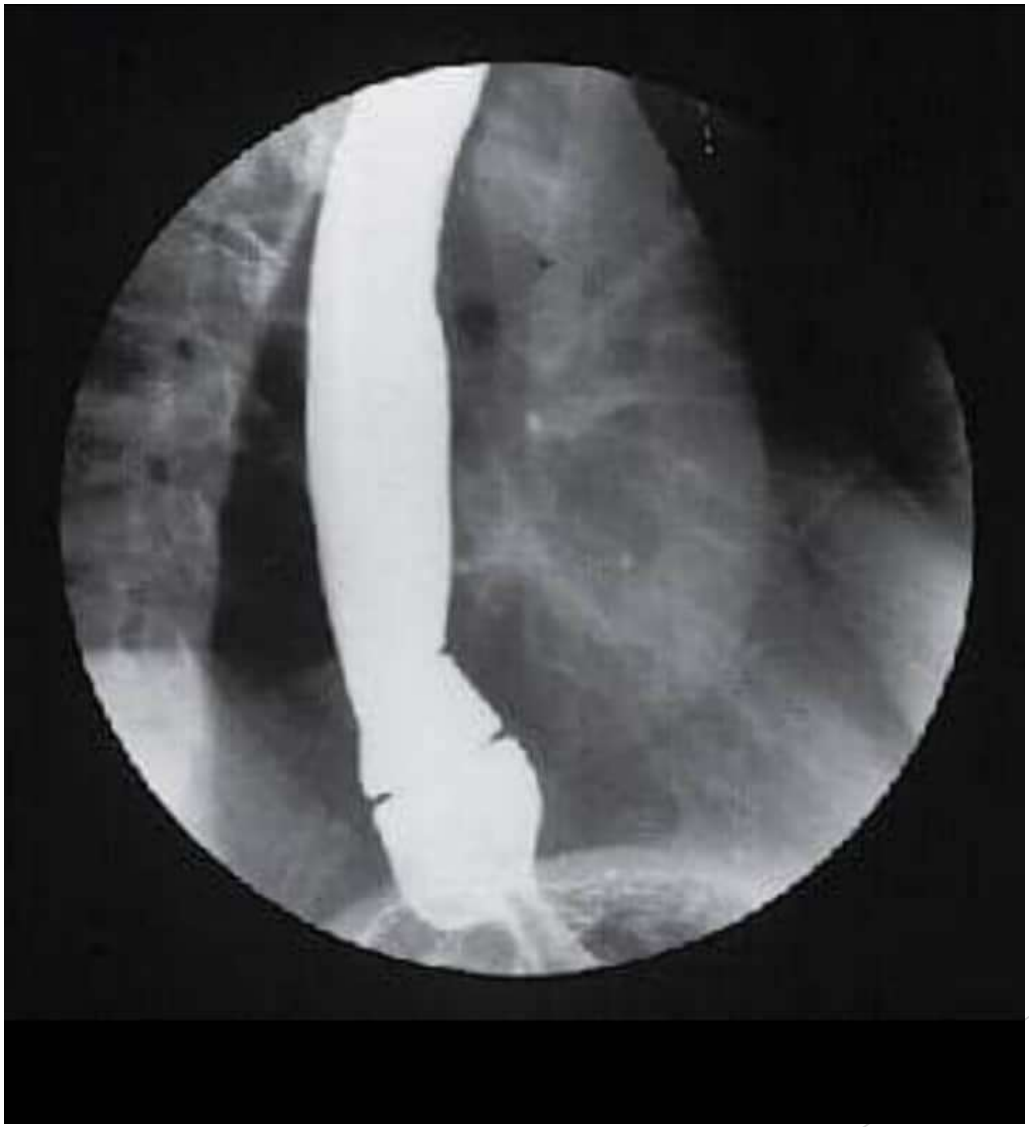
Plummer Vinson syndrome

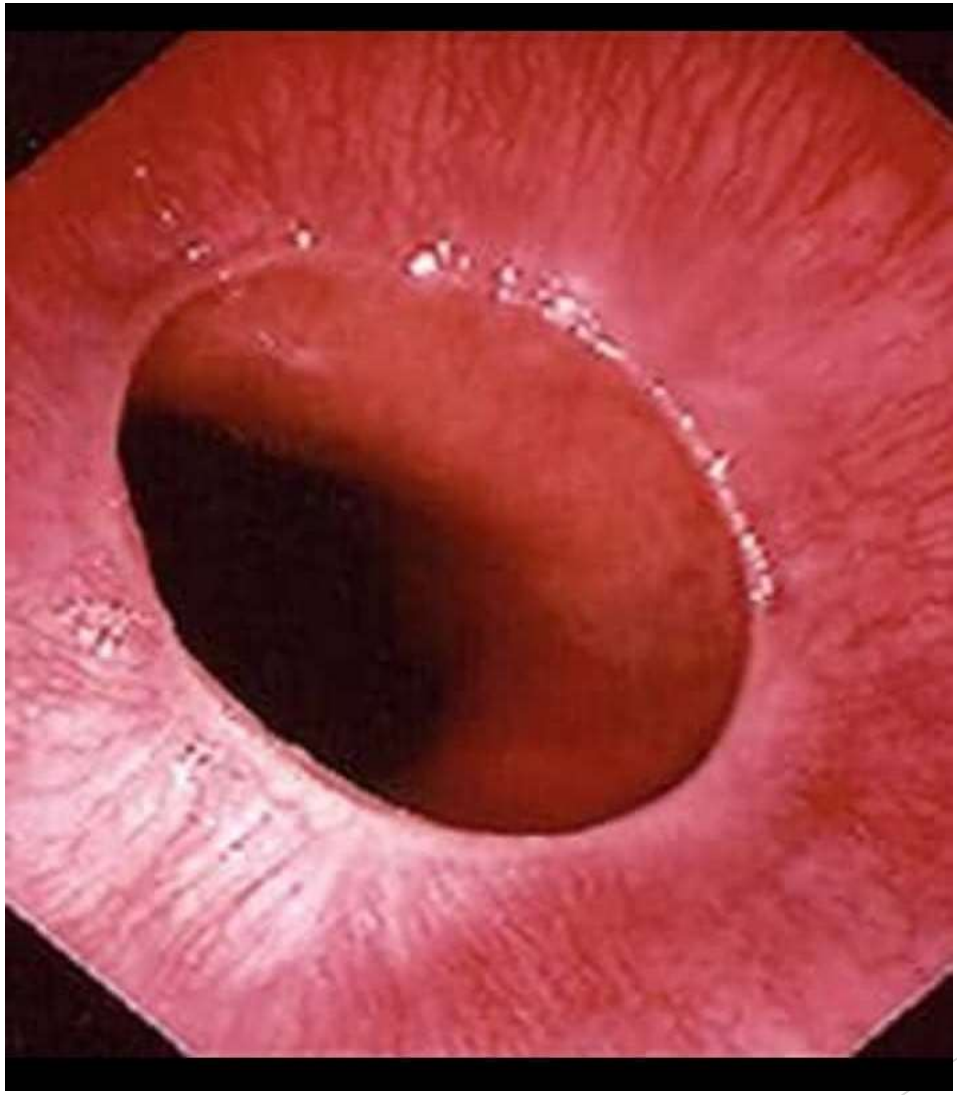


This barium swallow study obtained in a 53-year-old female with dysphagia and anemia demonstrates an upper esophageal web (black arrow) immediately above a tight stricture of the esophagus (white arrow).

Esophageal web on barium swallow







Liquid and/or solid dysphagia — Dysphagia to liquids alone or to solids and liquids may be related to either an esophageal motility disorder such as achalasia, distal esophageal spasm or hypercontractile

Achalasia — Primary achalasia is a disease of unknown etiology in which there is a loss of normal peristalsis in the distal esophagus and a failure of lower esophageal sphincter (LES) relaxation

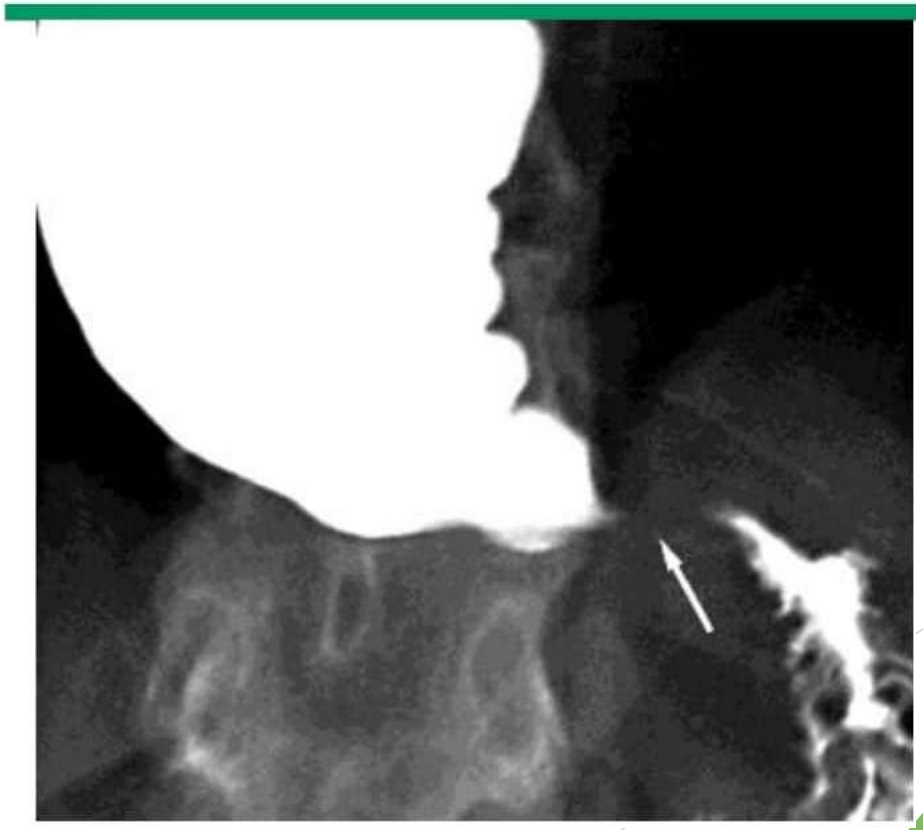
diagnosed in patients between 25 and 60 years. Men and women are affected with equal frequency. Progressively worsening dysphagia for solids (91 percent) and liquids (85 percent)

regurgitation of bland, undigested food or saliva are the most frequent symptoms in patients with achalasia. Other symptoms include chest pain, heartburn,

Achalasia

Achalasia

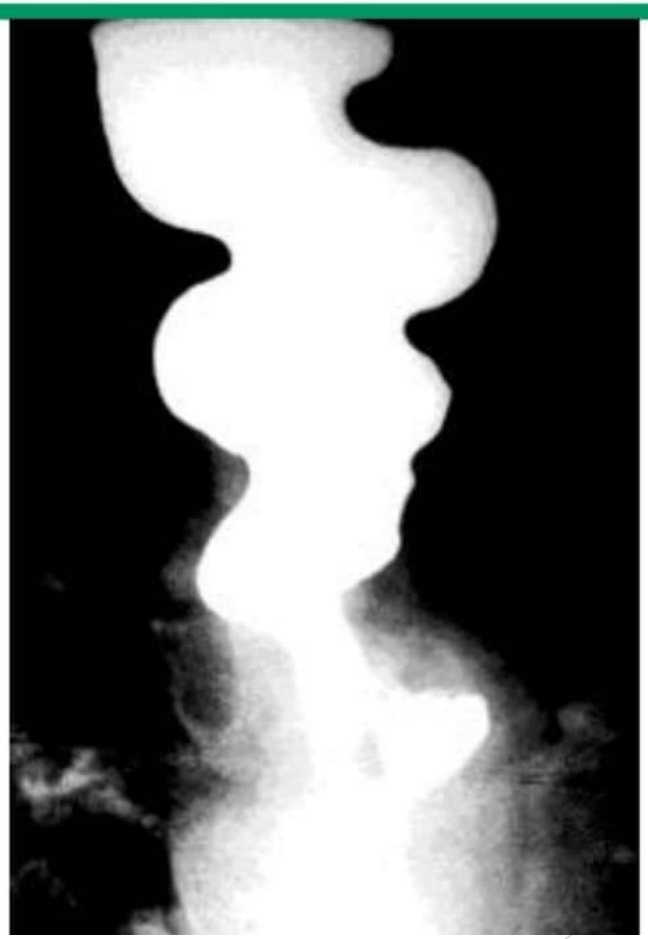
Dilation of the esophagus in a patient with achalasia (barium esophagram)



- **Hypertensive or spastic motility disorders:** Esophageal manometry is obtained to establish the diagnosis of a spastic esophageal motility disorder.

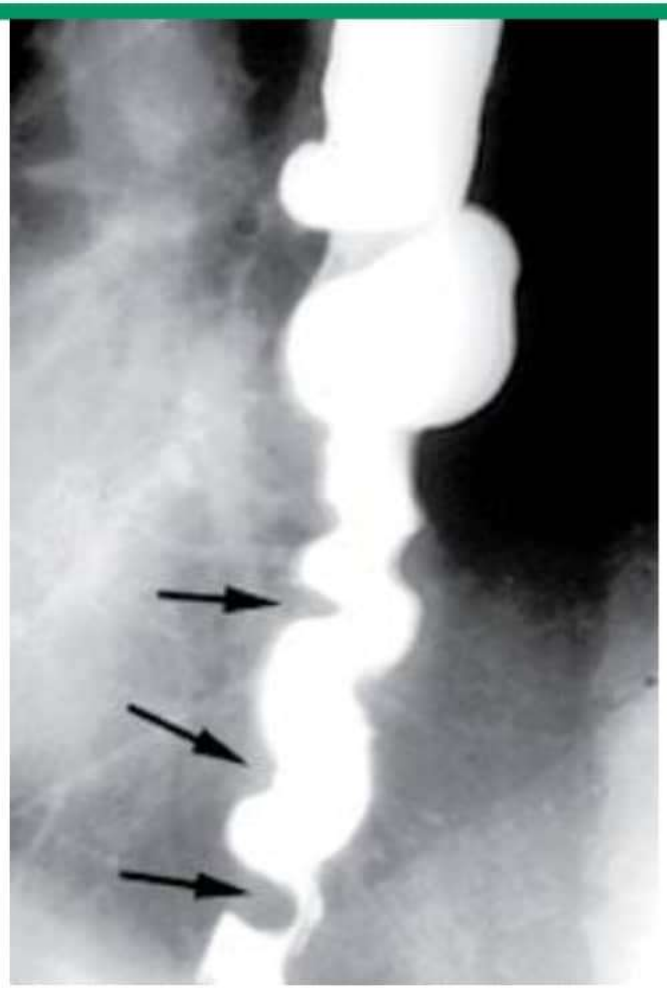
Corkscrew esophagus

Corkscrew esophagus



spasm

Diffuse esophageal spasm



Associated symptoms — Associated symptoms or findings can help to narrow the differential diagnosis

- Heartburn
- Weight loss
- Hematemesis
- Anemia
- Regurgitation of food

Functional dysphagia — According to the Rome IV criteria, functional dysphagia is defined by the following:

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- A sense of solid and/or liquid food lodging, sticking, or passing abnormally

- No evidence that an esophageal mucosal or structural abnormality is the cause of the symptom.

- No evidence that GERD or eosinophilic esophagitis is the cause of the symptom.

- Absence of a major esophageal motor disorder (achalasia, esophagogas

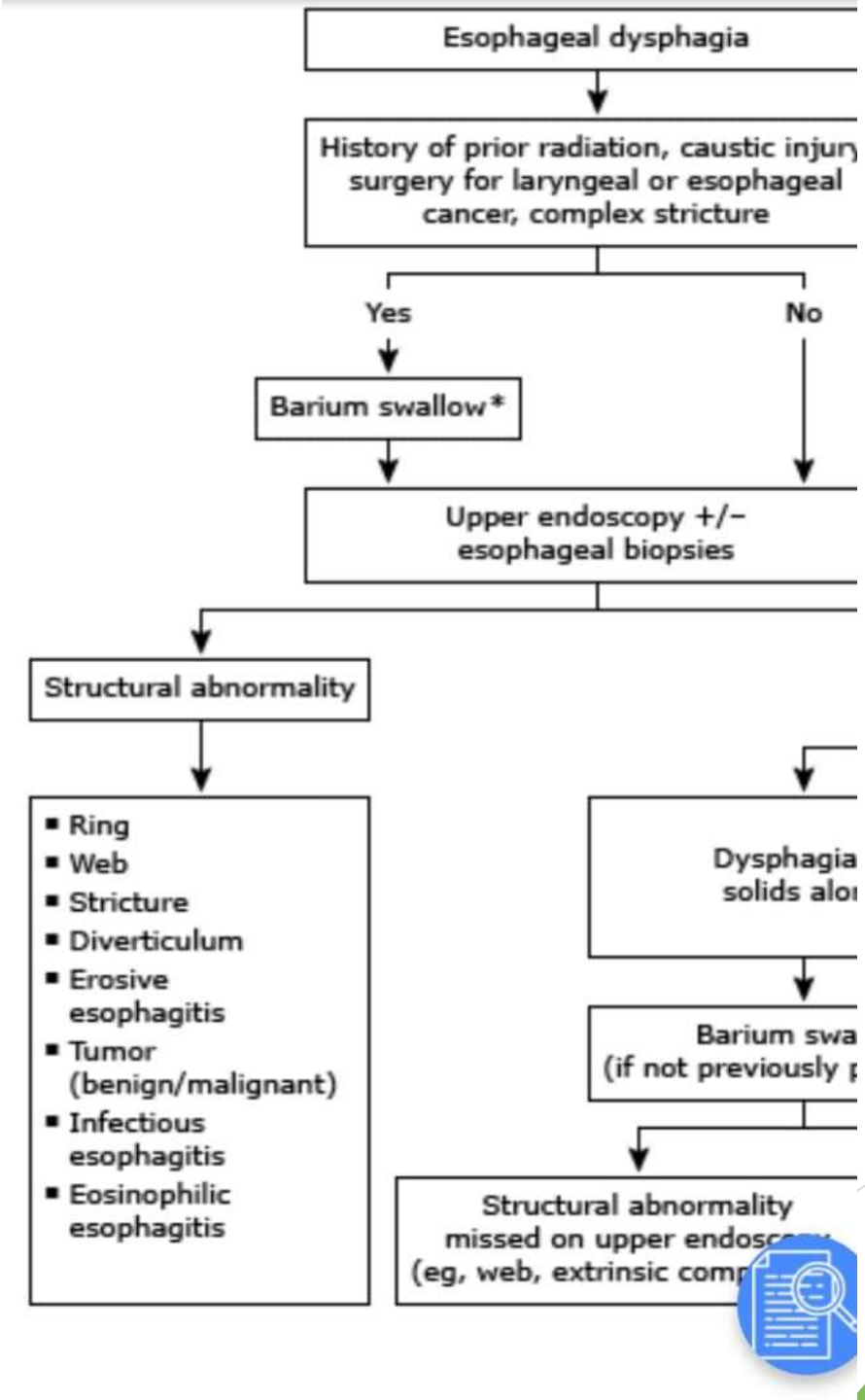
All criteria must be fulfilled for the past three months with symptom onset at least six months prior to the diagnosis

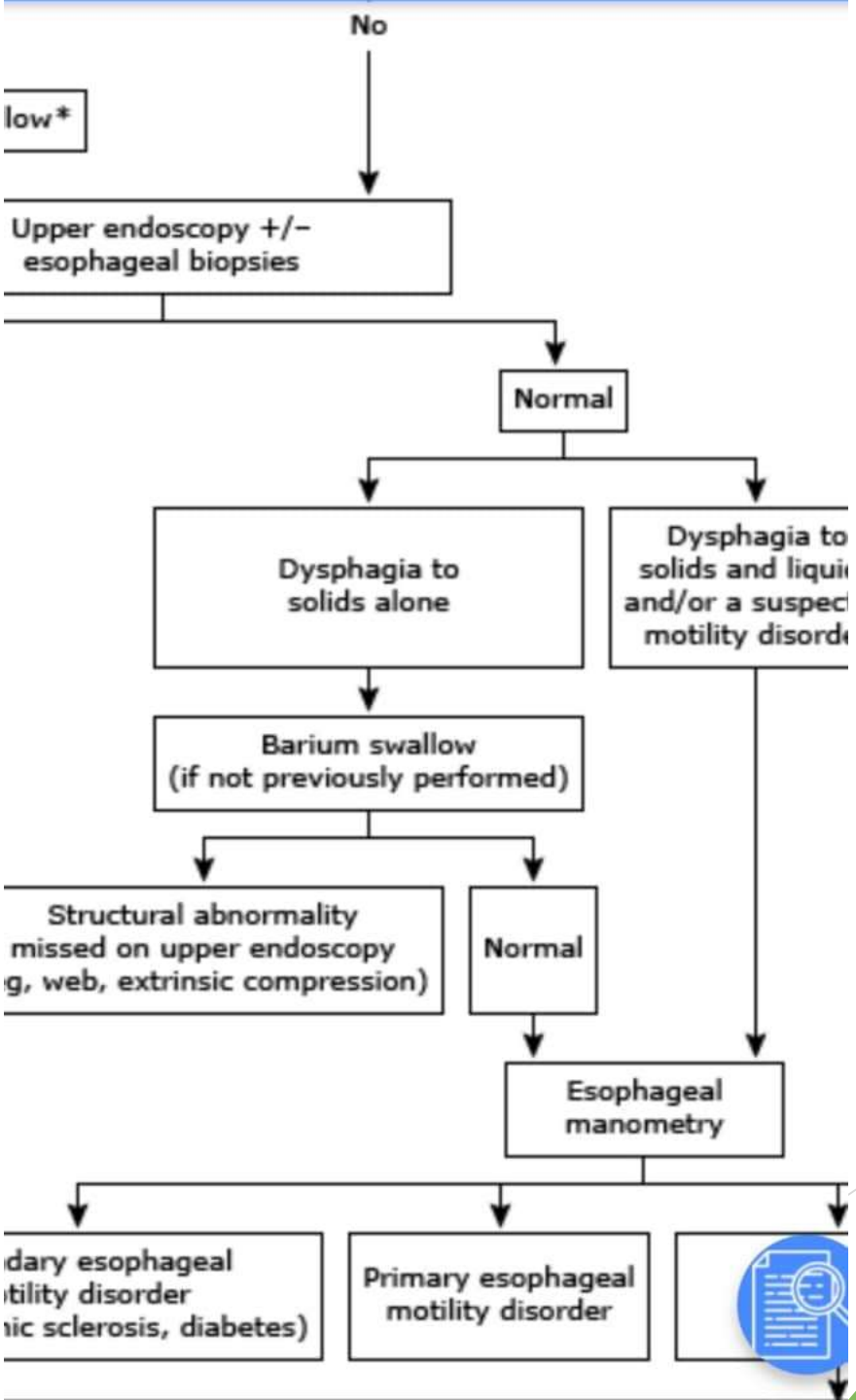
should be reassured and instructed to avoid precipitating

symptoms may improve with time. In patients with severe symptoms, despite these measures, a trial of a smooth muscle relaxant, such as a calcium channel blocker

tricyclic antidepressant, can be offered. This approach is similar to the initial treatment of distal esophageal spasm,

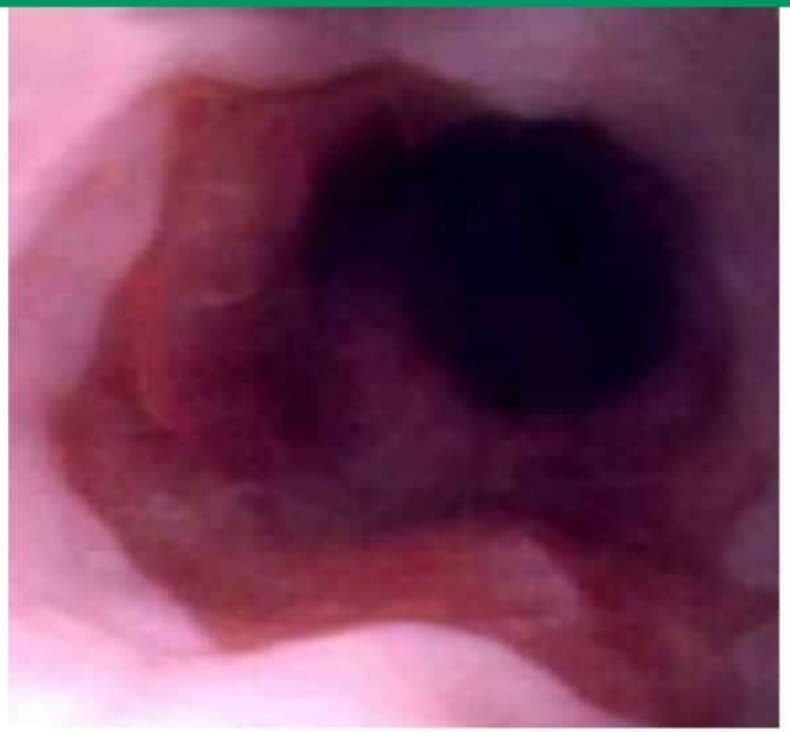
Empiric dilation with a mechanical (push-type or Bougie) dilator can be offered, but symptom response is variable.


Esophageal dysphagia
History of prior radiation, caustic injury
surgery for laryngeal or esophageal
cancer, complex stricture
Yes
No
Barium swallow*
Upper endoscopy +/−
esophageal biopsies
Structural abnormality
Ring
Web
Stricture
Diverticulum
Erosive esophagitis
Tumor (benign/malignant)
Infectious esophagitis
Eosinophilic esophagitis
Dysphagia
solids alo
Barium swa
(if not previously
Structural abnormality
missed on upper endosc
(eg, web, extrinsic comp


No
low*
Upper endoscopy +/−
esophageal biopsies
Normal
Dysphagia to
solids alone
Dysphagia to
solids and liqui
and/or a suspec
motility disord
Barium swallow
(if not previously performed)
Structural abnormality
missed on upper endoscopy
g, web, extrinsic compression)
Normal
Esophageal
manometry
dary esophageal
tility disorder
ic sclerosis, diabetes)
Primary esophageal
motility disorder

END

Barrett's esophagus: endoscopic appearance



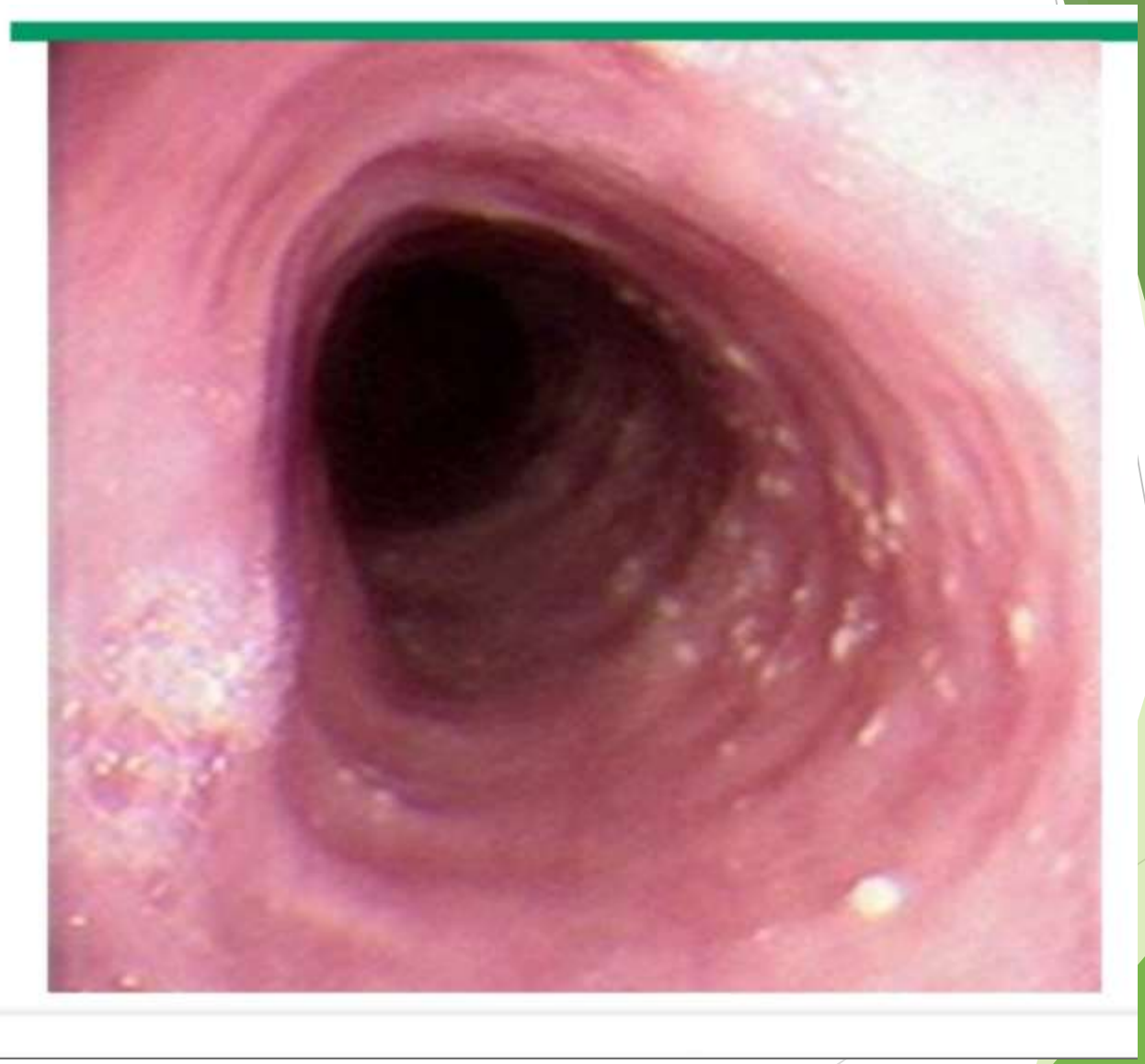
and a confirmed history of Barrett's esophagus or esophageal adenocarcinoma in a first-degree relative

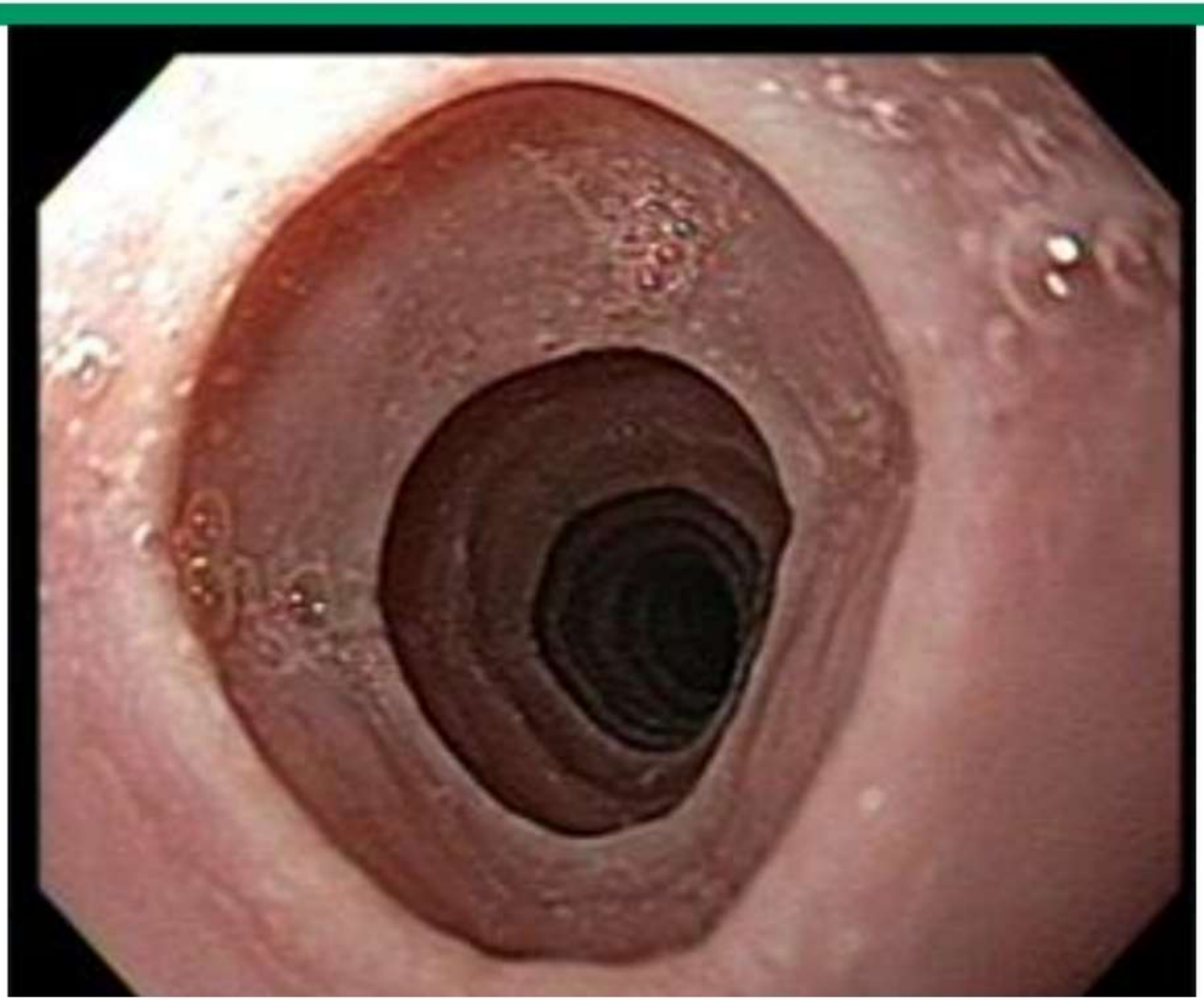
BARRETT'S ESOPHAGUS

Whom to screen — We screen for Barrett's esophagus in patients with multiple risk factors for adenocarcinoma.

These include a hiatal hernia, age ≥50, male gender, chronic gastroesophageal reflux disease (GERD), white race, central obesity, cigarette smoking,

An achalasia-like syndrome (pseudoachalasia) has been described in patients with adenocarcinoma of the cardia due to microscopic infiltration of the myenteric plexus or the vagus nerve [16]. Certain features





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Distal esophageal spasm (DES) and hypercontractile (jackhammer) esophagus can cause intermittent, nonprogressive dysphagia to solids and liquids.

45 **Systemic sclerosis (scleroderma)** — Patients with systemic sclerosis often have a history of heartburn and progressive dysphagia to both solids and liquids

secondary to the underlying motility abnormality or the presence of peptic stricture, which occurs in up to 50 percent of these patients [36]. The

presence of extracutaneous features and characteristic serum autoantibodies. Endoscopy may show erosive esophagitis or a peptic stricture resulting from acid

at least six months prior to the diagnosis and with a frequency of at least once a week.